

M e m o r a n d u m

To: Jose Arevalo, Administrator
Golden Cross Health Care of Pasadena
1450 N. Fair Oaks Avenue
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Date: February 6, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On December 13, 2011, the Operation Guardians team conducted a surprise inspection of Golden Cross Health Care, Pasadena. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. During the Operation Guardians (OG) morning walk-through of the facility, Resident 11-04-01 was observed lying supine in his bed awake, alert and conversed with the OG team. The OG nurse asked his assigned certified nursing assistant (CNA) if the resident was bedbound. The CNA reported the resident only got out of bed to go to the shower room. The team nurse monitored the resident's position in his bed for several hours and noted the resident was not being turned and repositioned by the staff to keep pressure off his sacral area. According to the resident's medical documentation he had a history of skin tears to his buttocks. The team nurse requested to assess the condition of the resident's skin to his sacral area.

The resident was able to assist the wound care nurse and CNA to turn to his left side in the bed for the skin assessment. It was noted the resident had several layers of incontinent fabric pads stuffed under his scrotum and perineal areas. The OG nurse questioned the use and positioning of the incontinent pads as the padding was causing unnecessary pressure and possible friction to the area's fragile skin. The CNA laughed, while standing next to the resident, saying he was *"too large to wear regular diapers."* The CNA's attitude and behavior towards this resident was of concern. This is a resident care and dignity issue.

During the skin assessment, the resident was observed with a Stage II pressure ulcer to the sacral area measuring approximately the size of a quarter. The wound care nurse stated that the breakdown was "newly acquired" and she would need to get a treatment order from the physician. The OG nurse questioned why the resident was not being turned and repositioned. The CNA reported the resident would "scream" when he was turned. However, when the OG nurse observed the resident being turned, he was cooperative and not expressing any type of discomfort. In reviewing the Care Plan, there was no notation that the resident refused to be turned or repositioned nor were there any notes about the resident screaming in pain when moved. There was also no plan for assuring the resident was turned and repositioned to avoid worsening of his pressure ulcer, or the development of additional ulcers.

2. Resident 11-04-02 was observed in his bed during the team's morning walk-through and he appeared as if he needed assistance. He was attempting to communicate with the team but his speech was garbled, thus making it difficult for the team to understand the resident's request. The team nurse looked around the bedside for some kind of communication device but no device was located. The call light was activated for the resident and a licensed nurse arrived and began asking the resident "yes/no" questions. The team nurse asked the facility nurse how they were able to understand his needs and she responded "*we are able to communicate fine with the resident.*" Appropriate communication devices need to be provided for this resident to assure he can communicate his needs.
3. According to the medical documents, Resident 11-04-03 had a Stage IV pressure ulcer to her right heel. Chart documentation indicated the resident was receiving wound debridement and treatment from a physician assistant. The Treatment Authorization Record (TAR) was reviewed by the OG nurse and was noted the wound care treatment orders were contradictory, as there were three separate orders for wound care. One order dated 12/5/11 instructed the nurses to "*add triple antibiotic to wound treatment every day for 30 days until 1/4/12.*" There was also an order written the same day to "*rinse the wound with hydrogen peroxide and normal saline 50% to 50% use PRN for 30 days until 1/4/12.*" On 12/6/11 an order was written to "*rinse the right heel with normal saline and pat dry. Apply Santyl ointment, cover with a dry dressing every day for 30 days.*" The wound care nurse reported she was implementing all wound treatments to the right heel wound as written on 12/5/11 and 12/6/11.

The OG nurse and OG Physician questioned the wound care nurse about the confusing orders. The physician explained to her the treatments would not work together, as one treatment would not allow the other treatment and vice versa to enter the wound bed. The licensed vocational nurse did not appear to understand the actions and indications for the treatments and had not questioned the physician or physician's assistant to clarify an accurate wound treatment. The team questioned the registered nurse in charge regarding the contradictory wound care orders and she indicated she would notify the physician to obtain the correct wound care order. There did not appear that there was adequate oversight by the registered nurses, nor was it apparent that this licensed vocational nurse had the required training and knowledge necessary to be the facility's wound care nurse. It was also noted that two daily wound treatments were not provided to the resident. There were blank areas on the TAR where initials should have been recorded by the licensed nurses. The treatments were not done on Friday, 12/9/11 and Saturday, 12/10/11.

4. Review of the TAR for Resident 11-04-04 showed a physician order for wound care had been written on 12/10/11 for treatment to the resident's "pustules on the left axilla." According to the TAR the resident had not received wound treatment on Sunday 12/11/11 or Monday 12/12/11, as the areas on the form were blank without licensed nurses' initials.
5. Review of the "Wound/Skin Healing Record" indicated Resident 11-04-05 had developed a Stage II pressure ulcer on the sacrococcyx area on 11/1/11. The record indicated the licensed nurse had measured the wound and provided the appropriate documentation in the record on 11/1/11. The record was dated on a weekly basis through 11/29/11, but there was no nursing documentation to indicate the wounds had been inspected, assessed, and measured. The wound assessment areas on the record were blank. There was also an additional "Wound/Skin Healing Record," dated 10/28/11 indicating the resident had a Stage I pressure ulcer to the sacrococcyx

area but the form had not been updated weekly by the licensed staff. It was confusing to the OG team why the facility had started an additional record or if the resident had two separate wounds. It appeared this resident was not receiving necessary wound care assessments by the licensed facility nurses.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. The storage room located by Room 120 was unlocked and contained heavy equipment, including floor buffers. This unlocked room was a potential safety hazard for confused residents. The floor required deep cleaning and the room was littered with debris, including empty soda cans.
2. Soiled gloves were observed on a bedside stand in Room 120. This is a health and safety issue as well as a possible infection control issue.
3. Room 113 was observed with soiled resident's clothing lying on top of the bedspread. There was also torn, peeling wallpaper observed under the soap dispenser.
4. The door of Room 113 was observed with a yellow sign that read "OXYGEN IN PLACE" but there was no oxygen in the room.
5. The storage room located by Room 113 was observed with unorganized durable medical equipment. This could cause problems if a resident needed medical equipment quickly, as the equipment would be hard to locate in this cluttered room.
6. Durable medical equipment such as wheel chairs and Geri-chairs were observed blocking pathways to many residents' rooms. This is a safety issue for the facility residents attempting to use the restroom or wanting to leave their room, or in case of an emergency. The vinyl on the armrests of the chairs was observed torn, which can cause tears to fragile elder's skin.
7. The furniture in the residents' rooms was very old and some of the furniture had broken drawers which needed repair. The furniture was also heavily soiled and required deep cleaning and/or replacement.
8. The residents' rooms and designated areas such as the hallways and doors were observed with scraped walls, chipped paint, soiled floors and deep ground-in dirt around baseboards.
9. A shower room was observed with feces on the floor. This is a health and safety issue for the facility residents, as well as an infection control issue.
10. Many residents were observed with their call lights out of reach. When this issue was brought to the attention of a CNA, she commented "*the resident doesn't use it anyway.*" Having call lights out of the reach of residents can be a possible neglect issue. Additionally, several residents told the team that their call lights were not answered in a timely manner. This was also mentioned in the Resident Council meeting notes.
11. The Clean Utility Room was observed with a metal cart containing left-over resident food trays. This is a health and safety issue.

ADMINISTRATIVE OBSERVATIONS:

1. Several of the facility residents did not appear to meet the level of care for 24-hour skilled nursing services. This was discussed with the business office personnel who reported the facility had four intermediate care beds. However, this facility is not licensed for intermediate care beds, but for 96 skilled nursing beds. The business office employee reported the facility had two current residents they were attempting to bill Medi-Cal for the intermediate level of care, but the requests were being deferred. The unauthorized level of care being provided at the facility was reported to the Department of Public Health.
2. Many of the certified nurse assistants (CNAs) were observed by the team nurse not wearing gloves when handling residents' soiled linen. The CNAs were walking out of the residents' rooms with the soiled linen in their arms and then placing the dirty linen in the receptacles in the hallways. The CNAs would then re-enter the resident rooms touching the privacy curtains and equipment without washing their hands. This is a health and safety issue and possible infection control issue.
3. Facility records showed that the facility was providing care for twelve (12) gastrostomy tube residents. These residents require a higher level of nursing care by a licensed nurse to administer the nutritional support, administer medications, provide supplemental hydration and check for tube placement. According to the staffing calculation by Operation Guardians (see below), the residents who had gastrostomy tubes may not have been provided with the appropriate licensed skilled nursing hours for the acuity of the residents.
4. It was also determined during the Operation Guardians inspection the facility was providing care for sixteen (16) bedbound residents. These residents require a higher level of nursing care due to the involvement of time required by the CNAs to provide all activities of daily living (ADLs) plus turning and repositioning the residents every two hours. These residents also require the licensed nurses to provide frequent, diligent skin checks. According to the staffing calculation by Operation Guardians (see below), there is concern the residents who were bedbound may not have been provided with the appropriate nursing hours for the acuity of the residents.
5. The facility did not have a Monthly Wound Care Log to effectively track residents' skin breakdowns. The DON was observed hand-writing a list of the facility residents with wounds she was copying from the weekly wound care sheets. The team was unable to determine from the information if the resident wounds had been acquired at the facility or during a hospitalization. According to the Weekly Wound Care Logs and observation of several of the resident's wounds, it appeared the facility was not providing quality skin checks, documenting any changes in the resident's skin condition, and implementing the appropriate nursing interventions to prevent skin breakdown and maintain skin integrity.
6. During the walk-through of the facility, more than three residents were observed with their breakfast trays sitting on their side table for more than 15 minutes. These residents were not assisted with eating and no staff took the trays back to warm the food.

STAFFING:

Based on the records provided by the facility, staffing levels were **below the 3.2 hours per resident day** (hprd) on two of the six days randomly reviewed. **The average hprd was 3.12 hours.**

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913, or Peggy Osborn at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
February 8, 2012

Golden Cross Health Care
December 13, 2011

The care and treatment of 14 residents was reviewed, comprising current residents and those who had recently been transferred to the hospital or died in the facility. Failures of nursing care were seen in almost every case. In particular, there was inadequate wound prevention and treatment, dehydration, inadequate psychotropic medication practices, and poor end-of-life care identified. Documentation by licensed nurses is extremely poor and facility staffing does not appear to be adequate, considering the large number of residents who are transferred back and forth to acute care hospitals.

I. Wound prevention and treatment

Two current residents with facility-acquired pressure ulcers were examined. In each case there were failures to provide basic preventive care. Resident 6 was also provided inadequate pressure ulcer care. She has had a number of admissions to acute care hospitals over the preceding four months, despite the fact that her advance directive states that she is to receive “comfort measures only.” She had been sent to the hospital on 8/14/11; one day earlier a nurse noted that her right heel was “soft to touch” with “mild redness,” felt to represent “possible cellulitis”. Upon her return to the facility 8/23/11, the right heel was described as a “deep tissue injury”. This likely represented the evolution of the right heel condition as described on 8/13, since the tissue over the heel bone becomes red, soft and inflamed when there has been prolonged pressure injury. It is not an area of the body that develops a localized bacterial infection, “cellulitis”. She was transferred to the hospital again on 9/23/11 because she “refused to eat”; laboratory tests at the hospital show that she was significantly dehydrated on 9/23, and she returned to the facility on 9/30 with a feeding gastrostomy tube.

Review of the pressure ulcer monitoring and treatment records shows that the wound has consistently deteriorated since 9/30/11. The monitoring records contain numerous identical measurements and overwritten entries, whereas a physician's assistant's measurements are notably different than those recorded by the facility's treatment nurse. The treatment nurse stated that she gives her measurements to the physician's assistant, but had no explanation for why her measurement differed from the PA's on the same date. The treatment nurse also had no explanation for how two completely different wound treatments were administered at the same time. There was an order for the application of a chemical debriding agent in place when the PA ordered a different cleansing agent and the application of a topical antibiotic. The treatment administration record shows that nurses were recording that both treatments were being provided every day since. It is very unlikely that nurses were actually providing both treatments, since

they are almost mutually exclusive of each other. More likely, nurses were initialing the treatment record, representing that the treatment had been done, when in fact it likely had not been, as the application of both treatments at the same time is nonsensical. This calls into question the veracity of the licensed nurse's charting.

Resident 11 also suffered a facility-acquired heel ulcer. She was admitted to an acute care hospital on 11/23/11 and was noted to have a blister on the left heel at the time which had not been described at the nursing home. (She was also severely dehydrated, discussed more below.) When she returned to the facility two days later, it was documented that she had a "suspected deep tissue injury" of that heel. According to the care plan entry made on the morning of our inspection, the ulcer had "resolved." However, I examined the resident and saw a full-thickness left heel ulcer and photographed it; clearly it had not resolved. Shortly after my examination of the resident, she was transferred to the hospital, for "fever and congestion". When I examined the resident, the charge nurse (LVN) told me she had administered acetaminophen to the resident, bringing down the "fever", but review of the medication administration record showed that no acetaminophen had been given. The transfer of the resident to the hospital and the "resolved" entry in the care plan were suspicious.

The failures of wound care and management are grossly evident in the case of Resident 14, who developed maggots in an open wound of his rectum. The resident was suffering from rectal cancer, which protruded in a fungated mass which was prone to bleeding. Although wound care to the mass was documented by nurses, and it was documented that the resident had been given showers, it seems very unlikely that it was kept clean and adequately treated in order to have developed maggots in it. The facility failed to report either an unusual occurrence or suspected neglect in this instance. The director of nurses stated that she had been on vacation during the entire month of July; the maggots were discovered on 7/13/11.

II. Dehydration

As noted above, both residents with heel ulcers were found to be dehydrated on admission to the hospital. In neither case did the facility list dehydration as a diagnosis for the resident, despite the fact that there was clear documentation of dehydration in hospital records contained in the facility chart. Likely dehydration contributed to the development of the heel ulcers in each case, and in addition was a marker of the nursing neglect—failure to reposition and to inspect the skin—that caused them.

In the case of Resident 11, she was receiving tube feeding at the time she became severely dehydrated, which suggests that nursing staff were not administering adequate water in the amount ordered. Her regimen of enteral nutrition and water provided more than her body's needs as estimated by the facility dietitian, and she gained weight on the regimen through 11/11. However, laboratory tests done on 11/9 showed elevations of sodium and blood urea nitrogen, consistent with inadequate water intake. The physician's note from 11/11 states that the plan was to provide "extra fluids" but no order for extra fluids was entered. Repeat laboratory tests were done on 11/14, and showed

further elevation of sodium, the only cause of which medically, is water deprivation. Nursing staff failed to take action on the abnormal labs reported 11/14, except to fax the results to the doctor. The next day the doctor ordered transfer to the hospital due to the abnormal laboratory results.

Another factor contributing to Resident 11's dehydration was the new development of diabetes. It is not uncommon to see that tube feedings, especially with weight gain, induce diabetes in older patients who are prone to diabetes anyway. Resident 11's lab results on 9/30/11 strongly suggested diabetes, with a fasting blood sugar result of 190 (normal, 60-100). Another laboratory test on 11/10/11 confirmed that she was diabetic, yet no action was taken by either the physician or facility nursing staff. With simple interventions to address the high blood sugar, likely the dehydration necessitating hospitalization (and contributing to the development of the left heel ulcer) would have been prevented.

The failure of the facility to list dehydration among the residents' diagnoses is also significant, since it is important for nurses and dietitians to know when a resident has become dehydrated at the facility. The development of dehydration is considered a "sentinel event" in nursing facilities.

III. Psychotropic medication practices

Deficiencies in this area included: inadequate verification of informed consent; inappropriate monitoring and lack of monitoring; and lack of monitoring for adverse drug effects. In two recent cases, Residents 5 and 7, nurses administering benzodiazepine tranquilizers failed to monitor for adverse effects and the indications for administering the drug were improper.

Resident 5 was transferred to the hospital for a "5150" (danger to self) evaluation on 11/29/11 and had not returned as of the day of our inspection. She was 69 years old and had been institutionalized for "many years", according to a hospital report; although there was no mental illness diagnosis listed on her face sheet, she was being treated with an antipsychotic drug and an anticonvulsant. Two days before her transfer to the hospital, she was "throwing food" and "constantly talking", for which nurses administered clonazepam, a Benzodiazepine tranquilizer. Nurses continued administering the drug, despite the resident's increasing agitated behaviors: she was verbally and physically aggressive "in spite of all med she received". Nurses demonstrated no awareness of the potential for the drug to make Resident 5's behavior worse.

Resident 7 was given Lorazepam for "paranoia", whereas lorazepam is an antianxiety drug, not indicated for treatment of this disorder. The resident's record shows that the drug was actually being given when she was "verbally aggressive" or resisting care and thus was being used as a chemical restraint. Because this drug can certainly make problematic behaviors like verbal aggression and resisting care *worse* instead of better, monitoring should have been done, but there was a failure to do so.

In another example of the failure to monitor for adverse effects, Resident 4, who suffers from bipolar disorder and is a paraplegic, has gained a significant amount of weight and is receiving high-dose Risperidone. This drug is known to induce weight gain, particularly at high doses and in younger individuals (Resident 4 is 59 years old). There is no evidence that the facility considered Risperidone as the cause for her weight gain, which places her at increased risk for a number of poor health outcomes as well as increases her care needs as a paraplegic. I did not find evidence in the record that the high dose, unchanged over the preceding 1-1/2 years, was warranted, as the resident has demonstrated no symptoms of any psychotic condition in recent times.

III. End of life care

A common failure among many of the cases reviewed was incorrect or absent completion of advance directives. The facility uses the POLST form, but in some cases there was no form on the current chart or the form was blank. In one case (Resident 1), the form had been signed by the physician but was not completed. The purpose of the physician signing the form is to acknowledge the resident's preferences for end of life care, so signing a blank form makes no sense. In another case, a red sticky-flag, "Sign Here" was affixed to a blank form, indicating that *the facility requested* that the physician sign the form before it was even completed.

As noted above, the facility appears to be disregarding the resident's advance directive as memorialized on the POLST form; residents are routinely transferred to the hospital despite a directive stating that s/he should be transferred only if "comfort needs cannot be met in the facility." In the case of Resident 11, transferred to the hospital for unclear reasons on the morning of our inspection, the POLST form in her chart was blank. Thus, the facility did not even consider whether Resident 11 wanted hospital transfer, and there was no documentation to suggest it had even been considered.

IV. Nursing process failures and understaffing

Nursing process failures were evident in almost every chart reviewed. Nursing assessments were absent, with very little registered nurse participation in day-to-day resident care. Care plans were absent, as in the case of Resident 1, who had no care plan for congestive heart failure despite having a known "severe" cardiomyopathy; he was sent to the hospital on 12/8/11 for obvious decompensation of his congestive heart failure. Care plans were generic, without measurable goals, and without updates to reflect changes to the treatment plan. Nursing documentation is poor, with numerous entries that do not even describe the resident's condition. For example, nurses repeatedly chart "all needs attended" whereas the resident's outcome demonstrates that this was not the case. A nurse charts, "still noted with persistent cough", while no previous nurse documented anything about a cough. Such examples were pervasive in the cases reviewed.

These failures reflect inadequate nurse staffing and insufficient supervision, especially of licensed nurses. Documentation seems aimed at merely "paper compliance," and there is

poor charting of the true condition of the resident. Residents are transferred to acute care hospitals at an alarming frequency, with the default position of nursing staff to transfer rather than assess and treat in the facility. The extra work required to transfer and then readmit the resident necessitates the need for more licensed nurses. On the day of our inspection, one charge nurse was assigned to 30 residents. CNAs were expected to take the vital signs of 30 residents before the charge nurse began the morning med pass, a very challenging assignment. Major improvements are needed to bring this facility's nursing department into compliance with generally accepted standards of quality care.

In conclusion, there were significant and troubling findings from this inspection, including deficient care which has harmed residents. This facility is not providing the appropriate and quality of care necessary for these residents.